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Service User Involvement in Training for the Therapeutic Management of Violence and Aggression

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Abstract

Involving service users in mental health education and training has increased considerably over the last few years, especially in the initial pre-registration training of mental health professionals (social workers, nurses, psychologists). There is a growing understanding of the important contribution that service users can make to developing the mental health practitioners of the future. Involving service users in the education of future mental health practitioners is seen as important in providing students with the opportunity for developing greater awareness and understanding through the unique insights of people's lived experience of mental health conditions, and of their contact with mental health services.

This paper describes the involvement of service user trainers in the development and delivery of a short training course in physical restraint for mental health professionals. It considers the impact of including service users who themselves have experience being restrained in acute mental health settings, from the perspective of course participants, tutors and the service user trainers themselves.

Key words: User Involvement, Therapeutic Management of Violence and Aggression, Manual Restraint, Mental Health Education.

Introduction

People with severe mental health problems represent some of the most vulnerable people in our society and are at greater risk of suffering violent assaults than the population as a whole (Borckardt et al 2007; Kumar, Guite and Thornicroft 2001; Mind 2007; Thornicroft 2006). Mental health service users experience violence from a variety of sources, including the general public, other service users on the wards, and even the professionals responsible for their care (Kumar et al 2001). Evidence shows that clinicians are quick to employ physical intervention in managing issues in inpatient mental health wards (Sheperd and Lavender 1999; Healthcare Commission 2006-7). However, if such interventions are not subject to rigorous safeguards, they may also represent a form of violence (Paterson 2005). There is a need therefore to provide training for competence in physical intervention skills for mental health professionals, especially nursing staff. This paper describes the development of a short course in the Therapeutic Management of Violence and Aggression (TMVA) at Middlesex University, and is written by members of the course team, including two service user trainers.

Training in Physical Restraint

The terms physical intervention and manual restraint are used to describe the skilled, hands-on method of physical restraint involving trained, designated healthcare professionals to prevent individuals from harming themselves or endangering others. Its purpose is to safely immobilise the individual concerned (NICE 2005).

Training for managing incidents of violence and aggression within health care environments has evolved over the last 30 years. During the early 1980s organised training in the form of 'Control and Restraint' Techniques was developed. Some of this training involved the use of

pain to gain compliance from the patient. This method of control with its origins in prison work was hard to justify within a health care environment and so alternative techniques in managing violence and aggression were developed, for example the General Services Association (GSA) model (General Services Association 2009), alongside national policy guidance and recommendations (Royal College of Psychiatrists 1998, Royal College of Nursing, 1997, British Institute of Learning Disaiblities, 2001, NHS Security Management Services, 2005 and 2007, Wright et al 2002). As well as using less forceful physical restraint techniques there is an increasing emphasis on the development and use of interventions aimed at prevention of violent incidents through risk assessment, recognising early warning signs, diffusion and de-escalation techniques (General Services Association 2009).

Physical intervention is the most commonly taught response for the management of violent behaviour in the UK and yet there is comparatively little research on its safety and effectiveness (Southcott and Howard 2007). In their study of inpatient aggression within a psychiatric inpatient setting, Shepherd and Lavender (1999) found that physical interventions were significantly more likely to be used than verbal interventions in managing aggressive incidents (approximately 65 per cent: 31 per cent respectively). The importance of training for safe physical restraint techniques is emphasised by research showing that inappropriate use of physical restraint increases the risk of injury to both service users and staff (Allen and Tynan 2000). Evidence of poorly executed physical restraint procedure can result in injuries and even death, such as the deaths in restraint of David 'Rocky' Bennett in 1998 and Gareth Myatt in 2004.

Nevertheless, physical intervention is considered to be a necessary and useful management tool in violent situations in mental health wards (Paterson 2007), and can have a therapeutic effect. Steckly (2008) found that when control and restraint was professionally and sensitively conducted for good reason, the therapeutic relationship and trust between staff and service user could be enhanced. One of the service users in Steckly's study said that he actually felt that the staff were protecting him and this increased his confidence in them. Another said that he had only ever been restrained by his key worker and that made him feel better in his relationship with this worker. It can also have a beneficial effect on the atmosphere on the ward as a whole. For example, Gilburt et al (2008) found that an experience of safety was maintained when staff demonstrated that they were able to control and contain situations, preventing them escalating and affecting other patients.

Training in the Therapeutic Management of Violence and Aggression (TMVA)

The General Services Association, formerly known as National Control and Restraint General Services Association, is the largest organisation for physical restraint training and accreditation in the UK. Following the GSA model (General Services Association 2009), the course tutors at Middlesex University have tried to promote the importance of caring for the non physical aspects of the restraint experience both for the person being restrained and the person applying the restraint. This has resulted in the development of a five day course in the 'Therapeutic Management of Violence and Aggression' (TMVA). This training runs from Monday to Friday and comprises one day theoretical and four days physical techniques training. The theory component conducted on the first day is designed to give course participants a comprehensive overview of the theoretical, legal and ethical issues associated with managing violence and aggression in healthcare settings, including recognition of potential violent situations, non touch interventions (Brennan 1999) and de-escalation skills. The practical component conducted over the remaining four days covers physical intervention techniques: a robust pack of techniques to manage a variety of threatening and physically challenging situations in healthcare settings. Participants on the course are continuously assessed over the five days with an assessment of practical skills on the final day. Successful completion of the course and the assessments entitles participants to a

certificate showing that they have passed a GSA recognised course which is valid for one year.

Tutors on the TMVA course have recognised the potential for rift between theoretical principles and application in practice and have looked at ways of reiterating principles of therapeutic management that engage more with course participants' motivation to take these on board more seriously. One such initiative has been to invite service users who have themselves experienced being restrained on a mental health ward to join the teaching team, initially as consultants and then as trainers.

Involving Service Users in Mental Health Education

User and carer involvement in mental health services has been a feature of government policy for over 20 years (Department of Health 1990; Griffiths 1989). During this time users and carers have taken an increasingly active role in the development of services (Rose et al 2002). With regards to mental health education, the National Service Framework for Mental Health proposes that service users should be involved in planning, providing and evaluating education and training (Department of Health,1999) and this is reiterated in the Chief Nursing Officer's review of mental health nursing (Department of Health 2006) and the Department of Health's Ten Essential Shared Capabilities (Department of Health 2004).

Research has shown that service user involvement in service development and planning can improve service outcomes (Carpenter and Sbaraini, 1997) and it is likely that this will also apply to service user involvement in education and training. Tew, Gell and Forster (2004) have argued therefore that if service delivery is to be characterised by an ethos of partnership, then such partnerships must also form the foundation of mental health education.

> By virtue of their direct experience of mental distress and of professional responses (helpful and unhelpful), service users and carers have valuable knowledge and expertise to offer (Tew et al. 2004, p.4).

Evaluations of service user involvement on student learning has shown that participants show more sensitivity and empathy, use less jargon and adopt a more individualised approach (Repper and Breeze 2007). Involving service users in mental health education has increased considerably over the last few years (Mental Health in Higher Education 2010). Much of this is in relation to initial training of social workers, nurses, psychologists and medical students, and mainly occurs in classroom teaching (McKeown, Malihi-Shoja and Downe 2010).

Service User Trainers' Experience with the TMVA Training

Two service users have helped to facilitate the TMVA training for the last two years. Existing service user educators on the mental health nurse training programmes at the university were asked if they had experience of being restrained themselves and would they like to be involved in training to share their experiences with course participants. One trainer was recruited in this way and volunteered to take part after some careful thought. Potential difficulties were discussed and considered. For example, the issues that would be discussed during the training could leave her feeling exposed, especially as some of the course participants work within the Trust where she receives her care and treatment. The training may also raise issues which might be distressing for her. However, the advantages seemed to outweigh the risks. Her experience of being involved in other aspects of teaching at the university, especially teaching pre-registration nurses, continues to be a positive one. She has always found that there has been support and reflective feedback after these sessions.

As a service user of mental health, she has never felt that her contribution has been tokenistic. She also thought that her experiences might help to improve attitudes and practice within mental health services and, finally, perhaps being part of the TMVA team might be fun.

The second service user trainer was recruited when a course tutor visited a local centre for African-Caribbean mental health service users to actively seek representation from this group to better reflect the perceptions and experiences of staff and service users on the inpatient units. The overrepresentation of young, black male service users in such settings is well documented. For example, a study carried out for the Campaign for Racial Equality and the Mental Health Act Commission (Browne 1997) found that 75% of all professionals interviewed thought that black clients were more likely to be seen as dangerous. One person volunteered to help with the training as he felt that he had experienced good and bad practice while being restrained and that he wanted to share those experiences with professionals.

The two service user trainers now lead a one hour session together on the final day of the course. At the beginning of the session when everyone has introduced themselves, they make it known that they welcome comments and questions from the participants and that they do not object to interruptions, in fact these are most welcome. They begin by telling their stories of being restrained and controlled whilst in a mental health setting. Both give a "good" experience as well as a "bad" one and explain why these experiences were considered as "bad" or "good". While telling their stories they explain why and how each one led to being restrained and what action followed the incident.

During the session, facilitators and participants explore together why the experiences of being restrained have been considered as "good" or "bad". They look at how the actions of staff involved in restraining patients can have a lasting effect and how such actions/inactions can be experienced as positive or negative, and as caring or punitive. Perhaps most important is the recognition of how important communication is and that if this aspect is right then this may prevent the need to restrain or it may bring about an early and safe termination of a restraint process.

Most sessions end up with a very lively and enjoyable discussion. The participants have on the whole been willing listeners and have joined in by asking questions, and at times those questions have felt quite challenging. There have been one or two sessions where the course participants have been very quiet, hardly asking any questions or making any comments. These sessions have felt like very hard work: "It's like pulling teeth!" After each session a feedback/de-briefing meeting takes place between all the trainers to check that all are comfortable and that the session has not opened up any old wounds. It is also an opportunity to share what they think has gone well. This short meeting is a very valued tool for both service user trainers.

> Hopefully my involvement will get staff to see that while they are restraining patients, those patients are real people with real feelings and who feel pain and fear. That staff return to their teams and that some of what they have heard filters down, so that good practice can be enriched. (Service User Trainer).
>
> The reason I like teaching is that it gives me time to bring out a lot of things that I have inside, good or bad. I have been doing this for two years. Plus it makes me feel good to know I can help improve the NHS. (Service User Trainer).

Course Participants' Feedback

At the end of every training course, participants are asked to complete an evaluation form consisting of a satisfaction rating and space for additional comments. The training, and especially the service user trainer session, is consistently rated very highly. The following quotes from course participants are only a few from the numerous expressions of appreciation of service users' input:

> Service user involvement makes it real. I appreciate this very much.
>
> The part that service users came to talk to us was eye opening and helped us to understand their plight.
>
> Service user element is the best addition in my view from previous courses – really puts emphasis on considering the client view
>
> Service user involvement is very relevant and thought provoking – a good way to see how our work affects/impacts patients.
>
> The involvement of service users has given me an understanding of need to de-brief patients after the procedure.

Course Tutors' Perspective

The involvement of service user trainers is also highly valued by the other members of the teaching team. It is seen as having boosted the authenticity of the team's resources and adds realism to what we teach. As suggested by Tew et al (2004:4):

> Service users' involvement has the capacity to enrich the learning of students, offering a more stimulating and challenging educational experience – and one which can equip students to practise more effectively.

A key element of the impact of this involvement is the creation of a forum where service users' contributions are intently listened to and valued by practitioners. It is an issue of concern to tutors that sometimes during training, especially during a role play, the person playing the 'patient' may complain about something but those playing the 'restraint team' are too preoccupied with the hands-on activity to listen. This is in spite of the emphasis tutors lay on listening and communicating effectively during a restraint process, in compliance with guidelines and recommendations (NICE 2005, Lyon and Pimor 2004). These role play experiences mirror what happens in real life incidents as seen in the results of formal inquiries e.g. the death in restraint of David 'Rocky' Bennett (Blofeld 2003).

Against this background, the focus of the service user involvement in the TMVA training with practitioners listening to service users and analysing what they are saying in order to learn lessons, and with service users in control of the session, can be seen as a powerful reversal of roles.

Conclusions and Implications for Practice and Service Development

Contribution to Physical Intervention Training

Service user involvement has boosted the quality of physical intervention training by adding realism to it. The consistently and unanimously positive feedback from clinicians participating in the training evidences this and makes the effort very worthwhile. The importance of this

achievement is magnified by the uniqueness of the subject area. Whilst service user involvement in mental health education has been gaining momentum over several years, this has taken place mainly within classroom teaching settings. Our experience on the TMVA training course has shown that service user participation in all aspects of learning and teaching activities is possible with careful planning and, as noted by Tew et al (2004), this could contribute significantly to effective learning and teaching.

This initiative has attracted wide interest. The teaching team including the service user trainers have been invited to present at workshops and conferences, including the annual conference of the GSA (General Services Association 2010). In sharing this experience, we are hoping that those physical intervention providers who are considering involving service users would feel reassured, and that those yet to do so would be encouraged to try.

Further Developments

The present arrangement of having the session on the final day of the course is currently under review. It is thought that having the service users' session earlier in the week would enable the course participants to reflect the points made by service users in their practice.

The positive reaction of course participants to service users' input has already set the scene for the next stage of the project – the evaluation of the impact of service user trainer input on staff practice when carrying out manual restraint in the ward setting. For this we are aiming to work collaboratively with practitioners and in-patients to observe and assess the effect of a service user centred approach to restraint on the quality of nursing care.

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